



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 11-02718-50

**Combined Assessment Program
Review of the
Hampton VA Medical Center
Hampton, Virginia**

January 11, 2012

Washington, DC 20420

Why We Did This Review

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Glossary

C&P	credentialing and privileging
CAP	Combined Assessment Program
CLC	community living center
EN	enteral nutrition
EOC	environment of care
facility	Hampton VA Medical Center
FY	fiscal year
MSDS	Material Safety Data Sheets
OIG	Office of Inspector General
QM	quality management
RN	registered nurse
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary: Combined Assessment Program Review of the Hampton VA Medical Center, Hampton, VA

Review Purpose: The purpose was to evaluate selected activities, focusing on patient care administration and quality management, and to provide crime awareness training. We conducted the review the week of September 26, 2011.

Review Results: The review covered eight activities. We made no recommendations in the following activities:

- Coordination of Care
- Management of Workplace Violence
- Medication Management
- Physician Credentialing and Privileging

The facility's reported accomplishment was the development and implementation of an educational campaign to increase awareness of how the facility promotes a safe environment. Staff, patients, and visitors receive updates on safety activities through lobby displays, Facebook® postings, and a safety-oriented internet page.

Recommendations: We made recommendations in the following four activities:

Environment of Care: Correct identified cleanliness deficiencies. Complete annual N95 respirator fit testing, and monitor compliance. Ensure the secure storage of medications and the prompt identification and removal of expired medications, and monitor compliance. Ensure that the hazardous material inventory and Material Safety Data

Sheets for all chemicals used are current.

Quality Management: Review each resuscitation episode, and ensure recommended actions are implemented.

Enteral Nutrition Safety: Ensure that enteral nutrition documentation in the community living center includes all required elements.

Registered Nurse Competencies: Ensure that competency folders contain all required documents and that competency documents contain all required signatures, initials, and dates.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected selected areas, interviewed managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- Coordination of Care
- EN Safety
- EOC
- Management of Workplace Violence
- Medication Management
- Physician C&P
- QM
- RN Competencies

The review covered facility operations for FY 2010 and FY 2011 through September 26, 2011, and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations from our prior CAP review of the facility (*Combined Assessment Program Review of the Hampton VA Medical*

Center, Hampton, Virginia, Report No. 08-00916-204, September 15, 2008). The facility had corrected all findings. (See Appendix B for further details.)

During this review, we also presented crime awareness briefings for 190 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishment

Safety Education Campaign

The facility initiated an educational campaign to increase staff, patient, and visitor awareness of the facility's efforts to promote a safe environment for anyone entering the facility. Facility leadership in patient safety, facility safety, emergency management, occupational health, security, infection control, and environment of care formed teams to provide educational opportunities and develop safety resources. Using an intranet web page, the teams publish safety briefings from items discussed in various committee meetings. In addition, they send e-mails to all staff and give in-services on safety topics. Binders containing information on reporting safety incidents or concerns are distributed to staff throughout the facility. Lobby displays and Facebook® postings inform staff, patients, and visitors about safety activities taking place at the facility.

Results

Review Activities With Recommendations

EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment in accordance with applicable requirements and whether the facility's domiciliary was in compliance with selected Mental Health Residential Rehabilitation Treatment Program requirements.

We inspected the intensive care unit, a medicine/surgical unit, the locked inpatient mental health unit, the emergency department, one of the CLC units, and the spinal cord injury unit. We also inspected the dental and women's health clinics, the domiciliary, and the Post-Traumatic Stress

Disorder Residential Rehabilitation Treatment Program units. The facility maintained a generally clean and safe environment. However, we identified the following conditions that needed improvement.

Cleanliness. The Joint Commission requires that facilities reduce the risk of infections associated with the storage of supplies and that areas used by patients are clean. VA requires that shelving be 8 inches above the floor to allow for proper cleaning, and local policy requires that all stored items that might attract pests be stacked off the floor when possible.¹ We found a storage room with multiple boxes on the floor and shelving that did not allow for cleaning under the bottom shelves. In addition, we found stained floor tiles in two bathrooms in the Mental Health Residential Rehabilitation Treatment Program and stained ceiling tiles in multiple locations throughout the facility.

Infection Control. The Occupational Safety and Health Administration requires that if facilities use N95 respirators, designated employees be fit tested annually. We reviewed 18 employee training records, and none of the employees had completed the required annual fit testing. However, while we were onsite, 15 employees completed the testing.

Medication Security. The Joint Commission requires that medications are safely stored and that expired medications are removed from use. In the intensive care unit, we found open drawers in a medication cart, an open drawer containing injectable medications and syringes, and an expired medication in a box with unexpired medications.

Environmental Safety. The Occupational Safety and Health Administration and The Joint Commission require that facilities maintain a current hazardous material inventory and MSDS for all chemicals used in clinical areas. We reviewed nine MSDS and found that eight were not current.

Recommendations

1. We recommended that the identified cleanliness deficiencies be corrected.
2. We recommended that annual N95 respirator fit testing be completed and that compliance be monitored.

¹ VA Handbook 7176, *Supply, Processing and Distribution (SPD) Operational Requirements*, August 16, 2002.

3. We recommended that processes be strengthened to ensure the secure storage of medication and the prompt identification and removal of expired medications and that compliance be monitored.

4. We recommended that processes be strengthened to ensure that the hazardous material inventory and MSDS for all chemicals used are current.

QM

The purpose of this review was to evaluate whether the facility had a comprehensive QM program in accordance with applicable requirements and whether senior managers actively supported the program's activities.

We interviewed senior managers and QM personnel, and we evaluated policies, meeting minutes, and other relevant documents. We identified the following area that needed improvement.

Review of Resuscitation and Its Outcomes. VHA requires facilities to review each episode of care where resuscitation was attempted to identify problems, recommend specific actions, and ensure those actions are implemented.² During the 12-month period from July 2010 through June 2011, the Special Care Committee met 10 times and deferred review of resuscitation episodes 7 times. Additionally, although a problem was identified, the committee did not ensure that recommended actions were implemented.

Recommendation

5. We recommended that processes be strengthened to ensure that each resuscitation episode is reviewed and that recommended actions are implemented.

EN Safety

The purpose of this review was to evaluate whether the facility established safe and effective EN procedures and practices in accordance with applicable requirements.

We reviewed policies and documents related to EN and patients' medical records. We also inspected areas where EN products were stored while conducting the EOC review, and we interviewed key employees. We identified the following area that needed improvement.

² VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

EN Documentation. VHA requires that staff document specific EN information in patients' medical records.³ We reviewed the medical records of 10 patients (5 CLC and 5 acute care) receiving EN. Four CLC patients' records did not contain all required information. For example, none of the four records included documentation of patient positioning, and two of the four records did not contain documentation of gastric residual checks.

Recommendation

6. We recommended that processes in the CLC be strengthened to ensure that EN documentation includes all required elements.

RN Competencies

The purpose of this review was to determine whether the facility had an adequate RN competency assessment and validation process.

We reviewed facility policy, interviewed nurse leaders, and reviewed initial and ongoing competency assessment and validation documents for 12 RNs. We identified the following area that needed improvement.

Competency Validation Documentation. Local policy requires that the verifier initial and date the competency document. Two competency documents lacked the verifier's initials, and one lacked the date of the competency assessment. In addition, one folder was missing FY 2010 competency documents.

Recommendation

7. We recommended that processes be strengthened to ensure that competency folders contain all required documents and that competency documents contain all required initials and dates.

Review Activities Without Recommendations

Coordination of Care

The purpose of this review was to evaluate whether the facility managed advance care planning and advance directives in accordance with applicable requirements.

We reviewed patients' medical records and the facility's advance care planning policy and determined that the facility generally met VHA requirements. We made no recommendations.

³ VHA Handbook 1109.05, *Specialized Nutritional Support*, May 10, 2007.

**Management of
Workplace
Violence**

The purpose of this review was to determine whether VHA facilities issued and complied with comprehensive policy regarding violent incidents and provided required training.

We reviewed the facility's policy and training plan. Additionally, we selected three assaults that occurred at the facility within the past 2 years, discussed them with managers, and reviewed applicable documents. The facility had a comprehensive workplace violence policy and managed the assaults in accordance with policy. The training plan addressed the required prevention and management of disruptive behavior training. We made no recommendations.

**Medication
Management**

The purpose of this review was to determine whether the facility employed safe practices in the preparation, transport, and administration of hazardous medications, specifically chemotherapy, in accordance with applicable requirements.

We observed the compounding and transportation of chemotherapy medications and the administration of those medications in the oncology clinic, and we interviewed employees. We determined that the facility safely prepared, transported, and administered the medications. We made no recommendations.

Physician C&P

The purpose of this review was to determine whether the facility had consistent processes for physician C&P that complied with applicable requirements.

We reviewed C&P files, profiles, and meeting minutes during which discussions about the physicians took place. We determined that the facility had implemented a consistent C&P process that met current requirements. We made no recommendations.

Comments

The VISN and Facility Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes D and E, pages 12–18 for the full text of the Directors' comments.) We consider Recommendation 1 closed. We will follow up on the planned actions for the open recommendations until they are completed.

Facility Profile⁴		
Type of Organization	Clinical referral medical facility	
Complexity Level	2	
VISN	6	
Community Based Outpatient Clinics	Virginia Beach, VA Elizabeth City, NC (opening November 10, 2011)	
Veteran Population in Catchment Area	265,068	
Type and Number of Total Operating Beds:		
• Psychiatry	40	
• Domiciliary	169	
• Spinal Cord Injury	64	
• Surgery	12	
• Medicine	24	
• CLC/Nursing Home Care Unit/Hospice	122	
Medical School Affiliation(s)	Eastern Virginia Medical School	
• Number of Residents	47	
	FY 2011 (through June)	Prior FY (2010)
Resources (in millions):		
• Total Medical Care Budget	\$243.7	\$230.1
• Medical Care Expenditures	\$136.6	\$128.7
Total Medical Care Full-Time Employee Equivalents	56	36
Workload:		
• Number of Station Level Unique Patients	35,851	36,639
• Inpatient Days of Care:		
○ Acute Care	25,469	25,375
○ CLC/Nursing Home Care Unit	21,168	22,590
○ Domiciliary	40,939	43,934
Hospital Discharges	2,223	2,457
Total Average Daily Census (including all bed types)	338	337
Cumulative Occupancy Rate (in percent)	66.2	68.3
Outpatient Visits	329,802	433,440

⁴ All data provided by facility management.

Follow-Up on Previous Recommendations		
Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
EOC		
1. Complete all corrective actions for duress alarms on the locked mental health unit.	All duress alarms are fully functional on the locked mental health unit.	N
2. Ensure all construction barriers are intact so clinical staff cannot enter construction sites.	An employee walked through a “plastic sheet” construction barrier to access some items. Since then, we have mandated use of drywall versus plastic, and the contractor is required to monitor/secure the area(s).	N
QM		
3. Develop a plan to review the privileges of all physicians to ensure competencies are current.	Competency and privileges are reviewed as part of service-level Ongoing Professional Practice Evaluation data. Quarterly Ongoing Professional Practice Evaluation reports are provided by the service to the Medical Executive Board.	N
4. Ensure all appropriate clinical staff maintain current cardiopulmonary resuscitation certification.	Cardiopulmonary resuscitation certification for non-nursing staff is monitored by the Medical Staff Coordinator and reported to the Medical Executive Board.	N
5. Ensure the peer review referrals from the mortality screening process occur more timely.	Mortality reviews are conducted.	N
6. Complete all elements of the root cause analysis process in accordance with VHA policy.	All root cause analysis is in compliance with the VHA directive.	N

Recommendations	Current Status of Corrective Actions Taken	Repeat Recommendation? Y/N
7. Ensure that disclosure processes comply with VHA policy.	Clinical disclosures are done by providers. Tracking of clinical disclosures when an incident report is entered in Veterans Health Information Systems and Technology Architecture is noted in the incident log, which is reviewed by leadership monthly. The patient safety manager tracks clinical disclosures. The risk manager is tracking institutional disclosures.	N
Pharmacy Operations		
8. Evaluate and properly seal clean room ceilings.	Pharmacy clean room ceilings were inspected and appear to continue to have a good seal.	N
9. Install an automatic door switch leading into the main clean room.	The automatic door switch leading to the main pharmacy clean room was tested and is fully functional.	N
10. Install an automatic light switch in the chemotherapy clean room.	An automatic light switch was installed in the pharmacy chemotherapy clean room.	N

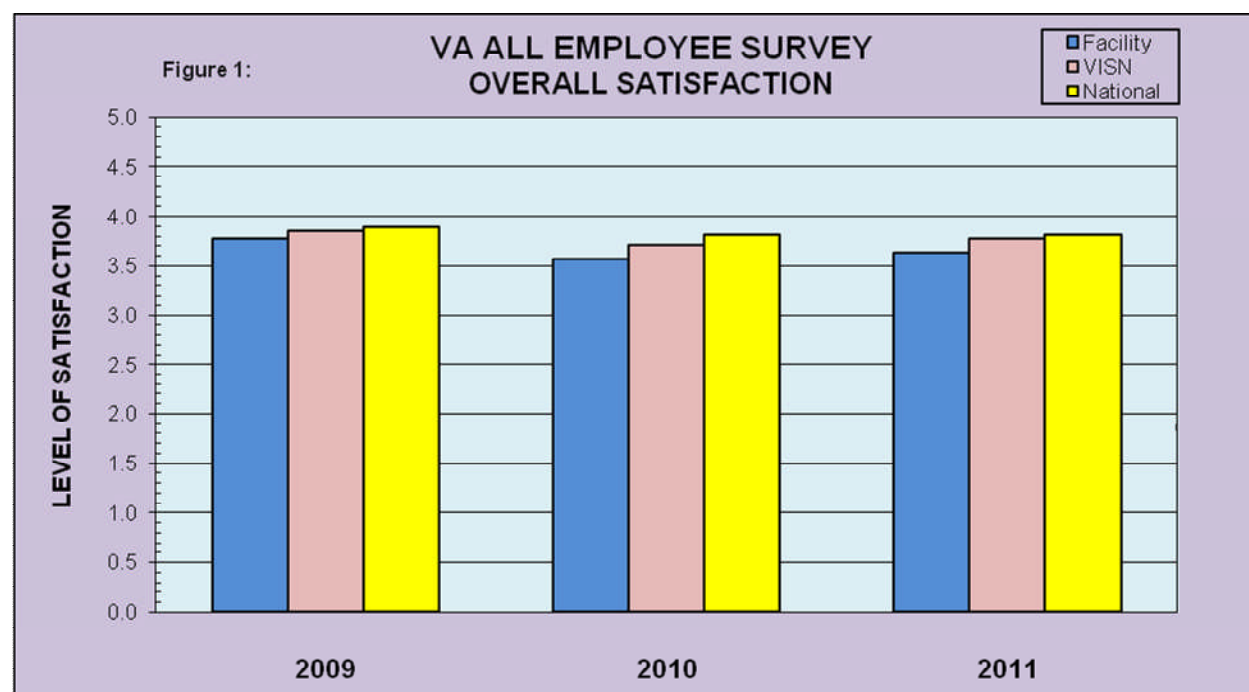
VHA Satisfaction Surveys

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores and targets for quarters 3 and 4 of FY 2010 and quarters 1 and 2 of FY 2011.

Table 1

	FY 2010			FY 2011		
	Inpatient Score Quarters 3–4	Outpatient Score Quarter 3	Outpatient Score Quarter 4	Inpatient Score Quarters 1–2	Outpatient Score Quarter 1	Outpatient Score Quarter 2
Facility	56.4	44.3	29.6	53.7	41.0	35.8
VISN	62.0	52.2	46.5	62.8	50.1	49.5
VHA	64.1	54.8	54.4	63.9	55.9	55.3

Employees are surveyed annually. Figure 1 below shows the facility's overall employee scores for 2009, 2010, and 2011. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



Hospital Outcome of Care Measures

Hospital Outcome of Care Measures show what happened after patients with certain conditions received hospital care.⁵ Mortality (or death) rates focus on whether patients died within 30 days of being hospitalized. Readmission rates focus on whether patients were hospitalized again within 30 days of their discharge. These rates are based on people who are 65 and older and are “risk-adjusted” to take into account how sick patients were when they were initially admitted. Table 2 below shows facility and U.S. national Hospital Outcome of Care Measure rates for patients discharged between July 1, 2007, and June 30, 2010.⁶

Table 2

	Mortality			Readmission		
	Heart Attack	Congestive Heart Failure	Pneumonia	Heart Attack	Congestive Heart Failure	Pneumonia
Facility	**	10.3	12.1	**	25.9	18.0
U.S. National	15.9	11.3	11.9	19.8	24.8	18.4

** The number of cases is too small (fewer than 25) to reliably tell how well the facility is performing.

⁵ A heart attack occurs when blood flow to a section of the heart muscle becomes blocked, and the blood supply is slowed or stopped. If the blood flow is not restored timely, the heart muscle becomes damaged. Congestive heart failure is a weakening of the heart’s pumping power. Pneumonia is a serious lung infection that fills the lungs with mucus and causes difficulty breathing, fever, cough, and fatigue.

⁶ Rates were calculated from Medicare data and do not include data on people in Medicare Advantage Plans (such as health maintenance or preferred provider organizations) or people who do not have Medicare.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: Dec 1, 2011

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CAP Review of the Hampton VA Medical Center,
Hampton, VA**

To: Director, Washington, DC, Office of Healthcare Inspections
(54DC)

Director, Management Review Service (VHA 10A4A4
Management Review)

1. The Mid-Atlantic Health Care Network submits the following responses to recommendations resulting from the Office of Inspector General visit dated September 26–30, 2011. We concur with the findings and have initiated processes to prevent any future occurrences.
2. Thank you for providing me the opportunity to review the document and respond.
3. If you have any questions and/or concerns, please feel free to contact the Medical Center Director, DeAnne M. Seekins, MBA, at (757) 722-9961, ext. 3100.

(original signed by:)
DANIEL F. HOFFMANN

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 1, 2011

From: Director, Hampton VA Medical Center (590/00)

Subject: **CAP Review of the Hampton VA Medical Center,
Hampton, VA**

To: Director, VA Mid-Atlantic Health Care Network

1. I have reviewed the draft report and concur with the recommendations. The findings outlined in the OIG report reflect a thorough evaluation.
2. We have implemented processes to ensure that variations in the processes are resolved.

(original signed by:)
DEANNE M. SEEKINS, MBA

Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

OIG Recommendations

Recommendation 1. We recommended that the identified cleanliness deficiencies be corrected.

Concur

Target date for completion: December 15, 2011

Facility Response:

The identified stained floor tiles in the Mental Health Residential Rehabilitation Treatment Program will be replaced by December 15, 2011.

On September 29, 2011, the boxes of supplies that were located on the floor in the storage room on the Medical/Surgical unit have been removed and the supplies have been placed on a rolling elevated platform in the supply room that allows for accessibility for cleaning under the platform.

On September 26, 2011, the two bathrooms identified as being in need of cleaning on the Mental Health Residential Rehabilitation Treatment Program were immediately terminally cleaned.

On September 26, 2011, the stained ceiling tiles identified in multiple locations were immediately replaced.

Recommendation 2. We recommended that annual N95 respirator fit testing be completed and that compliance be monitored.

Concur

Target date for completion: January 31, 2012

Facility Response:

At the time of survey, a significant percentage of Medical Center staff were designated as requiring N95 Respirator Fit Testing due to the H1N1 risks. A Risk Reassessment was immediately conducted to determine the priority of areas requiring immediate Fit Testing. Based on this reassessment, medical evaluations were conducted and Fit Testing was completed for approximately eighty (80) employees the week of September 26, 2011. On October 3, 2011, a tracking log for N95 Fit Testing was

developed and is currently being utilized by the Safety Department to track and monitor annual testing of employees.

The Safety/Industrial Hygiene Department is currently conducting in-depth reassessments to identify staff required to complete the annual N95 Fit Testing based on the facility MCM. Based upon the results of the reassessments completed as of November 28, 2011, 72% of applicable employees have been medically evaluated and Fit Tested for the N95 respirator. Documentation to validate these medical evaluations and Fit Testing is maintained in the Safety Department in a tracking log. All reassessments will be completed to identify employees requiring fit testing by December 9, 2011. Consequences for not completing the Fit Testing include supervisory notification, just in time Fit Testing and employees not being able to perform patient care involving at risk patients. The N95 Respirator Fit Testing will be tracked monthly and reported monthly to the Environment of Care Committee for Executive Leadership oversight.

Recommendation 3. We recommended that processes be strengthened to ensure the secure storage of medication and the prompt identification and removal of expired medications and that compliance be monitored.

Concur

Target date for completion: December 15, 2011

Facility Response:

A process for the appropriate storage for medications is currently in place within our facility; however, during our survey the Intensive Care Unit (ICU) medication cart was not secured. Based on a facility review, it was determined that the medication drawer on the medication cart did not catch when the lock was engaged. A "Quick Sweep" form that is utilized facility wide identifies areas of focus to facilitate a continuous survey readiness posture. The Quick Sweep form was updated on November 22, 2011 to include validating the functionality of the Medication Cart(s) locking mechanism and expired medications. If the locking mechanism is not functional, staff are to immediately notify Pharmacy Services to have the cart repaired or replaced. Any expired medications will be returned to Pharmacy for appropriate disposal. Nurse Managers will be educated regarding the revised Quick Sweep form during the December 14, 2011 External Review meeting.

The revised process is to have the Nurse Managers perform and document a weekly "Quick Sweep". Each Nurse Manager will educate the Nursing staff on the revised Quick Sweep process by December 30, 2011. The Nurse Managers will report the results of their weekly "Quick Sweep" monthly to the Nursing Executive Leadership Board (NELB) for Executive Leadership oversight.

Pharmacy Service continues to inspect all ward and clinic stock of pharmaceuticals monthly on an on-going basis and any outdated, deteriorated or excessive stock of

medications is immediately removed and is reported quarterly to the Pharmacy and Therapeutics Committee.

Recommendation 4. We recommended that processes be strengthened to ensure that the hazardous material inventory and MSDS for all chemicals used are current.

Concur

Target date for completion: January 31, 2012

Facility Response:

During the week of September 26, 2011, the Medical Center focused on conducting MSDS inventories for the inpatient clinical areas to validate the accuracy of existing inventory binders. Based on these inventories, the lists were updated to reflect the most current chemicals maintained in each inpatient clinical area. During weekly Environment of Care (EOC) rounds, MSDS binders are reviewed for accuracy. Any identified discrepancies are tracked by the Safety Department until corrected by the applicable service.

Based on the identification of this issue, facility-wide MSDS reviews were initiated. Every Service Chief will complete a review to validate the accuracy of their MSDS binder by January 31, 2012. The status of the reviews for each workplace's MSDS binder is tracked and reported monthly to the Environment of Care Committee for Executive Leadership oversight.

In addition, the MSDS management program is currently being transitioned to the VHA Center for Engineering and Occupational Safety and Health (CEOSH) on-line MSDS management program.

Recommendation 5. We recommended that processes be strengthened to ensure that each resuscitation episode is reviewed and that recommended actions are implemented.

Concur

Target date for completion: December 15, 2011

Facility Response:

In October 2011, the Special Care Committee reviewed the current code critique sheet and revised the cardiac events critique sheet to capture, at a minimum,

1. Errors or deficiencies in technique or procedures,
2. Lack of availability or malfunction of equipment,
3. Appropriateness of interventions performed against national standards of care,
4. Clinical issues or patient care issues such as failure to rescue, which may have contributed to the occurrence of a cardiopulmonary event, and

5. Delays in initiating CPR both in house, and problems in obtaining the assistance of Emergency Medical Services or use of the 911 call system when the event occurs on campus

The Special Care Committee was re-educated on the requirements of VHA Directive 2008-063, related to cardiac event critiques. Additionally, members of the Code Team will be educated by December 15, 2011 on the revised cardiac event critique.

As of November 2011, the Special Care Committee reviews monthly the revised critique sheets for each individual cardiac event; to include Code Blue, Code Green and Rapid Response; for review, discussion, analysis and trending, as prescribed in VHA Directive 2008-063. The data will then be aggregated and analyzed.

Special Care Committee will use this analyzed cardiac event data to identify problems, analyze trends, and benchmark to identify opportunities to improve both process and outcomes. Special Care Committee will recommend specific actions when problems are identified and ensure those actions are implemented, and tracked until closure. The monthly report of these findings will be reported to Executive Leadership Board (ELB) through Medical Executive Board (MEB) and Nursing Executive Leadership Board (NELB) for clinical and executive oversight.

Recommendation 6. We recommended that processes in the CLC be strengthened to ensure that EN documentation includes all required elements.

Concur

Target Date For Completion: March 1, 2012

Facility Response:

An Enteral Nutrition Workgroup has reviewed the documentation requirements as outlined in the Journal of Parenteral and Enteral Nutrition article, ***Enteral Nutrition Practice Recommendations*** dated January 27, 2009. The workgroup is in the process of combining our Medical Center Memorandum (MCM) 11-58, Nutrition Support Team and the GREC Service Memorandum 171B-40 into one facility document that incorporates all the documentation requirements addressed in the above article. The new draft MCM is projected to be completed by January 3, 2012 and will then be forwarded for review and concurrence. The projected date for approval of the MCM is February 1, 2012.

A Provider Order Template that incorporates the documentation requirements as outlined in the above article is currently in the draft development process and is projected to be completed by January 3, 2012. The Provider Order template is projected to be implemented by February 1, 2012. All Long Term Care Provider's will be educated on the Enteral Nutrition Provider Order template by February 1, 2012. Beginning in March 2012, Service Chiefs in Long Term Care will perform monthly medical record reviews to validate the Provider Order template is being utilized for residents or patients receiving Enteral Nutrition. Results of the monthly medical record

reviews will be reported to the Medical Executive Board (MEB) for Executive Leadership oversight.

A Nursing Documentation Template that incorporates the documentation requirements as outlined in the above article is currently in the draft development process and is projected to be completed by January 3, 2012. The Nursing documentation template is projected to be implemented by February 1, 2012. All Long Term Care Nursing staff will be educated on the Enteral Nutrition Nursing Documentation Template by February 1, 2012. Beginning in March 2012, Associate Chief for Nursing Services (ACNS) for the Long Term Care units will perform monthly medical record reviews to validate the Nursing Documentation Template is being utilized for residents or patients receiving Enteral Nutrition. Results of the monthly medical record reviews will be reported to the Long Term Care Management Council and the Medical Executive Board (MEB) for Executive Leadership oversight.

Recommendation 7. We recommended that processes be strengthened to ensure that competency folders contain all required documents and that competency documents contain all required initials and dates.

Concur

Target date for completion: February 15, 2012

Facility response:

Nursing Service will conduct a 25% review of competency folders for required documentation by December 31, 2011. Then the remaining 75% will be reviewed by February 15, 2012 and findings reported to the Nurse Executive Leadership Board. The Associate Chief of Nursing Education will conduct a random review of 25% of the folders the 2nd and 4th quarter then report to NELB. The audits will be conducted utilizing an audit tool that had previously been developed and utilized to perform competency folder reviews.

OIG Contact and Staff Acknowledgments

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